Claims Clues

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ESP Claims to be Reviewed Case by Case

Claims for services provided to recipients eligible under the Emergency Services Program (ESP) will be reviewed by the AHCCCS Administration on a case by case basis.

Claims must be submitted to AHCCCS with documentation that supports the emergent nature of the services provided. For a claim to be considered for reimbursement, the services billed must meet the federal definition of emergency services:

Emergency services are services that:

- Are *medically necessary*, and
- Result from the *sudden* onset of a health condition with *acute* symptoms, and
- Which, in the absence of *immediate* medical attention, are reasonably likely to result in at least one of the following:
  - Placing the individual's health in *serious jeopardy*, or
  - *Serious impairment* to bodily functions, or
  - *Serious dysfunction* of any bodily organ or part.

Providers must attach supporting documentation to the HCFA 1500 or UB-92 claim form submitted to AHCCCS for all services rendered to ESP recipients. The documentation must verify the medical emergency as defined in the federal guidelines. Providers should not attach the entire medical record.

Providers also must check the emergency box on the HCFA 1500 claim form (Field 24I). The Admit Type (Field 19) on the UB-92 must be a "1" to identify the services billed as an emergency.

Providers should continue to follow the billing instructions in the *Fee-For-Service Provider Manual.*

Questions about *covered services* should be directed to the AHCCCS Office of Medical Management at (602) 417-4241.

Questions about *billing* should be directed to the AHCCCS Claims Customer Service Unit at:

- (602) 417-7670 (Phoenix area)
- (800) 794-6862 (In state)
- (800) 523-0231 (Out of state) ❒

ESP Claims from Physicians Require Documentation

All physician claims for services rendered to recipients eligible under the Emergency Services Program (ESP) providers must include documentation substantiating the medical emergency.

The October issue of *Claims Clues* indicated that physicians did not need to submit documentation for inpatient emergency services and for services rendered in an emergency room because the facility also would be submitting documentation.

However, because processing of physician claims could be delayed if AHCCCS did not have the facility's documentation available for review, it was determined that physicians should submit documentation for all services rendered to ESP recipients. This will allow AHCCCS to process physician claims faster, and it will also avoid AHCCCS having to ask for records during retrospective reviews.

Examples of documentation include operative reports, progress notes, summary letters, etc. The documentation must verify the medical emergency as defined in the federal guidelines. Providers should not attach the entire medical record. ❒

Providers Must Bill Delivery Only Codes for ESP Recipients

Maternity claims for Emergency Services Program (ESP) recipients must be billed using the appropriate CPT code for delivery services only.

Claims for ESP recipients billed with a global CPT code will be denied.

Previously, if providers billed using the global CPT code, AHCCCS would reimburse the provider for delivery services only.

(Continued on Page 2)

Providers Must Bill Delivery Only Codes for ESP Recipients

(Continued from Page 1)

Providers may only bill the following codes for labor and delivery services for ESP recipients:

59409 - Vaginal delivery only

59514 – Cesarean delivery only

59612 - Vaginal delivery only, after previous Cesarean delivery

59620 - Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery ❒

Medicare Crossover Billing Rules Clarified

AHCCCS has completed the automated crossover process for fee-for-service claims from providers whose Medicare carrier or intermediary is BlueCross/ BlueShield of North Dakota (Noridian), BlueCross/BlueShield of Arizona, and BlueCross/Blue-Shield of Texas (TrailBlazer Health Enterprises).

When a provider submits a claim to Medicare for an AHCCCS recipient who also is Medicare eligible, the claim is automatically crossed over to AHCCCS when Medicare issues payment. Providers should not submit claims to AHCCCS for paid Medicare claims for dually eligible AHCCCS recipients or QMB recipients. All Medicare crossover claims are identified on the provider's remittance advice.

Denied and adjusted Medicare claims are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS within six months from the date of the Medicare EOMB. A copy of the EOMB must accompany the claim to AHCCCS. These claims must achieve clean claim status within six months of the date of the Medicare EOMB or 60 days of the last adverse action by AHCCCS, whichever is later.

When billing AHCCCS for AHCCCS-covered services that are not covered by Medicare, providers must submit the initial claim within six months of the date of service. The claim must achieve clean claim status within 12 months of the date service.

When submitting claims for AHCCCS-covered services not covered by Medicare, providers must "zero fill" the Medicare coinsurance and deductible fields on the claim form.

Providers who have questions about submitting claims for dually eligible AHCCCS recipients or QMB recipients should contact the Claims Customer Service Unit at:

- (602) 417-7670 (Option 4)
- 1-800-794-6862 Ext. 7670 (In state)
- 1-800-523-0231 Ext. 7670 (Out of state) ❒

Tax ID Required to Direct Reimbursement Correctly

For the past three years, AHCCCS has required providers to enter their tax identification number on all fee-for-service claims submitted to the AHCCCS Administration.

Now that tax ID number – not a locator code – will determine the address to which payment is sent.

Previously, a provider's two-digit service address locator code (01, 02, 03, etc.) was linked to one or more pay-to addresses. A provider's pay-to address is the address on the reimbursement check from AHCCCS.

Providers should continue to append the service address locator code to their AHCCCS provider ID number to indicate the location where a service was performed. However, using the locator code will no longer direct payment to a specific address.

If a provider's record shows more than one address linked to a tax ID number, the system will direct payment and the Remittance Advice to the first address with that tax ID number.

Providers who want reimbursement checks directed to more than one address must establish a separate tax ID for each address.

Providers must then enter the appropriate tax ID on the claim form to direct payment to the correct address.

If no tax ID is on file, the AHCCCS system will deny the claim because it will be unable to direct payment to a specific address.

Providers who have questions about tax ID information on file with AHCCCS should contact the AHCCCS Provider Registration Unit at:

- (602) 417-7670 (Option 5)
- 1-800-794-6862 (In state)
- 1-800-523-0231 (Out of state) ❒